AGENCY DYSPHAGIA PLAN MONITOR

RESIDENT	LOCATION AND PROVIDER	EMPLOYEE WORKING WITH RESIDENT:	DATE	TIME

ACTIVITY(S) OBSERVED (CHECK ALL THAT APPLY):
BKFT ____ LUNCH ____ DINNER ____ SNACK ____ MED PASS _____ CHANGING/DRESSING _____ ORAL CARE _____ BATHING _____ DENTALAPPT _____

	GENERAL DYSPHAGIA REVIEW			
1	Can staff define *dysphagia*?	Yes	No	
2	Can staff articulate what health risks are associated with dysphagia?	Yes	No	
3	Can staff describe the symptoms associated with dysphagia?	Yes	No	
	RESIDENT SPECIFIC REVIEW-DYSPHAGIA			
4	Does staff know at what level of dysphagia the resident is at risk?	Yes	No	
5	Does staff know what triggers, specific to this resident, require notifying the nurse?	Yes	No	
6	Is the resident's Dysphagia Plan present in the area?	Yes	No	
7	If adaptive equipment is identified on the Dysphagia Plan, is it present?	Yes	No	N/A
8	Is adaptive equipment being used in accordance with the plan?	Yes	No	N/A
9	Is the resident positioned in the manner defined by the Dysphagia Plan or Positioning Plan?	Yes	No	N/A
10	Is the resident transferred or repositioned in a manner consistent with the Dysphagia Plan or Positioning Plan?	Yes	No	N/A
11	Is the resident's intake provided in manner consistent with the Dysphagia Plan, e. g. food consistencies, liquids, tube feedings etc.?	Yes	No	N/A
12	Is staff prompting the resident to eat in a manner consistent with his/her Dysphagia Plan, e. g. small bites, slower pace, etc.	Yes	No	N/A
13	Is the Dysphagia Plan effective in keeping the resident safe? • If NO, immediately contact the nurse.	Yes	No	
14	Does staff know the intended outcome of the dysphagia plan?	Yes	No	
	PHYSICAL AND NUTRITIONAL MANAGEMENT			
15	During the observation, has the resident experienced any of the following that were unable to be corrected? (If so, immediately contact the nurse) ☐ Coughing w/signs of struggle (watery eyes, drooling, facial redness) ☐ Wet vocal quality and/or breath sounds ☐ S/S of discomfort and/or being improperly positioned ☐ Inoperable or unavailable wheelchair			
16	How many uncorrected dysphagia triggers have occurred since the last review? ☐ 0 triggers ☐ 1-5 triggers ☐ 5-10 triggers ☐ > 10 triggers			
17	If uncorrected triggers were documented, was Nurse and appropriate therapist notified?	Yes	No	N/A
18	Is the individual free from any reddened areas and / or skin breakdown?	Yes	No	
19	If No, was Nurse and appropriate therapist notified?	Yes	No	N/A
20	Is the individual's weight within their goal range?	Yes	No	
21	If no, was Nurse and/or Registered Dietician notified?	Yes	No	N/A
22	Was IDT held to address observed risks and changes made to plans (dysphagia, dining, positioning) to reflect client's needs?	Yes	No	N/A
23	Issues Corrected On-Site	Yes	No	N/A
24	Additional Corrective Action Required	Yes	No	N/A
25	Additional Corrective Action Completed	Yes	No	N/A

TRAINING OF THE FOLLOWING WAS COMPLETED:_____

_____

_____STAFF SIGNATURE_____

PROVIDE WHAT # WAS TRAINED. STAFF SIGNATURE VERIFIES THAT THEY HAVE BEEN TRAINED ON ANY OBSERVED DEFICITS.

AGENCY DYSPHAGIA PLAN MONITOR

ACTIONS TAKEN TO ADDRESS IDENTIFIED ISSUES IN THE MONITOR :		
PERSON COMPLETING MONITOR:	TITLE:	DATE